



Mercy San Juan Medical Center
Community Benefit Report 2014
Community Benefit Implementation Plan 2015



A Message From:

Brian Ivie, President and CEO of Mercy San Juan Medical Center, and Sister Brenda O’Keeffe, Chair of the Dignity Health Sacramento Service Area Community Board

The **Hello humankindness** campaign launched by Dignity Health is a movement ignited and based on the proven idea that human connection, be it physical, verbal, or otherwise, leads to better health. At Dignity Health, the comprehensive approach to community health improvement recognizes the multi-pronged effort needed to meet immediate and pressing needs, to partner with and support others in the community, and to invest in efforts that address the social determinants of health.

Mercy San Juan Medical Center, a part of the Dignity Health Sacramento Service Area, shares a commitment to improve the health of our community and offers programs and services to achieve that goal. The 2014 Annual Report and 2015 Plan for Community Benefit fulfills section 501 (r) of the Patient Protection and Affordable Care Act, where each hospital must complete a community health needs assessment every three years and develop a community health implementation plan to document how it will address the significant health needs of the community. We are proud to provide this report as a continuation of the work we have done for nearly 50 years to better the health of the communities we serve.

In addition, California State Senate Bill 697 requires not-for-profit hospitals to annually report community benefit efforts and measurable objectives as well as plans for the coming year. Encouraged and mandated by its governing body, Dignity Health complies with both mandates at all of its facilities, including hospitals in Nevada and Arizona, and is proud of the outstanding programs and services that have been offered to improve the health of the communities we serve.

In fiscal year 2014, Mercy San Juan Medical Center provided \$55,083,056 in financial assistance, community benefit, and unreimbursed patient care. Including the unreimbursed cost of caring for patients covered by Medicare, total expense was \$71,555,755.

The Dignity Health Sacramento Service Area Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 23, 2014 meeting. Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 916 851-2731.



Brian Ivie
President and Chief Executive Officer
Mercy San Juan Medical Center



Sister Brenda O’Keeffe
Chair, Dignity Health Sacramento Service Area
Community Board

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EXECUTIVE SUMMARY

Established in 1967, Mercy San Juan Medical Center is located at 6501 Coyle Avenue, in Carmichael, CA, where it serves the areas of north Sacramento and south Placer County. The hospital holds a Level II designation in trauma care and in 2014, was named by Healthgrades as one of America's 100 Best Hospitals for Critical Care, and received Healthgrades' Distinguished Hospital Award for Clinical Excellence.

The hospital has 2,300 employees, 370 licensed acute care beds, and 31 emergency department beds. Tertiary care specialties include a 26-bed Neonatal Intensive Care Unit that is ranked among the best in the world for survival rates of premature infants, and an accredited Sleep Center to treat sleep disorders. Mercy San Juan Medical Center is the only hospital in the Sacramento region that provides hyperbaric oxygen therapy to treat patients with tissue damage, and has the largest and most advanced Lung and Esophageal Center in Northern California for diagnosing and treating lung disease. Mercy San Juan Medical Center and its sister hospital, Methodist, are the only two hospitals in the Sacramento region to offer minimally invasive orthopedic surgeries using the advanced MAKO robotic system. The hospital is also widely known for expertise in treating complex diseases affecting the brain in collaboration with sister hospital, Mercy General, at the Mercy Neurological Institute of Greater Sacramento.

Mercy San Juan Medical Center must continuously balance its responsibility caring for the acutely ill with the increasing role it serves as a safety net provider for the poor and vulnerable in a region where public and community capacity is severely limited. The region's safety net is challenged by a lack of access to both primary and mental health care, the absence of a care coordination system, and minimal health prevention and education options for underserved and at-risk populations. These challenges are reflected in alarming hospital utilization trends and through assessments of the community, and serve as the basis for community benefit planning and programming.

In FY 2014, the hospital further advanced a number of core community benefit programs in partnership with others in the community that respond to these priority health issues, and laid the groundwork for new initiatives in FY 2015. Highlights include:

Patient Navigator Program

The Patient Navigator Program represents an innovative partnership between Mercy San Juan Medical Center and sister Dignity Health hospitals, Medi-Cal insurer, Health Net, community nonprofit, Sacramento Covered, and community clinics working together to increase access to care. The program engages navigators in the emergency department to directly assist patients admitting for non-urgent care. Navigators connect patients to a medical home, coordinate their care, follow their progress and offer other social support services, including transportation, when needed. Partners use health information exchange technology to share health data and to track patient outcomes. In the first year since launching the program in August 2013, the program is achieving its intended goals to improve quality of health, reduce emergency department admissions for non-urgent care, and lower health care costs. Nearly 4,000 patients were assisted in calendar year 2014, with 80% receiving follow-up appointments with a primary care provider or clinic. Initial evaluation shows a significant reduction in emergency department readmissions - as much as 68%, by those patients assisted.

WellSpace Health Capacity Building Project

A \$2.8 million investment by Mercy San Juan Medical Center in partnership with Mercy Hospital of Folsom is enabling one of the region's Federally Qualified Health Centers, WellSpace Health, to build three new full service clinics in parts of the region that lack safety net services. WellSpace Health opened its first clinic in the City of Rancho Cordova in February 2013. The site features a children's dental unit in addition to 12 primary

care exam rooms. In the first year of operation, the new Rancho Cordova Health Center had 12,500 primary care visits and 7,000 oral health visits.

WellSpace Health's new San Juan Community Health Center located nearby the hospital in Carmichael received its Change in Scope approval from the federal government in FY 2014 and is now preparing to celebrate its grand opening. WellSpace Health expects to be in contract for one of two potential clinic sites in Folsom in late fall 2014.

All in all, the three new clinics will expand safety net capacity to serve over 40,000 new patients. The hospital and WellSpace Health are working to integrate systems in order to coordinate patient care and improve quality of care.

Healthier Living Chronic Disease Self-Management Program

Mercy San Juan Medical Center, in partnership with sister Dignity Health hospitals, fills a major gap for health prevention and education services in the region through its Healthier Living program. It is the only Chronic Disease Self-Management Program available at the community level that responds to the extremely high prevalence of chronic disease among underserved populations in Sacramento County. Following the evidence-based model developed by Stanford University School of Medicine, Healthier Living offers general chronic disease and diabetes specific workshops in both English and Spanish. Workshops are held regularly at community clinic sites, low-income housing developments, food banks and other convenient locations for participants. In FY 2014, 21 workshop series were conducted, and over 80% of all participants in these workshops increased their self-efficacy and were able to avoid hospitalization as a result of new skills and education gained.

ReferNet Intensive Outpatient Mental Health Partnership

The hospital expanded its partnership in FY 2014 with nonprofit mental health provider, El Hogar, to address a serious need in the community for mental health services. The ReferNet program evolved from the Dignity Health Community Grants Program and enables the hospital to link patients who admit to the emergency department to El Hogar for immediate follow-up and long-term intensive outpatient mental health care. The hospital was able to find appropriate mental health care through this partnership with El Hogar for 243 patients in FY 2014.

Details on these programs, a number of new initiatives in development, and other community benefit investments by Mercy San Juan Medical Center are documented in more detail in this report. The total value of community benefit for FY 2014 is \$55,083,056, which excludes \$16,472,699 in unpaid Medicare costs.

MISSION STATEMENT

We share the mission of Dignity Health:

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- delivering compassionate, high-quality, affordable health services;
- serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- partnering with others in the community to improve the quality of life.

ORGANIZATIONAL COMMITMENT

A commitment to improving the health of the community has been an essential part of Mercy San Juan Medical Center's mission for nearly 50 years. The hospital is proud of its history of investing in community health programs and partnering with others to identify and address urgent health needs in the community it serves.

Every three years, the hospital conducts a Community Health Needs Assessment (CHNA) that brings administrative and clinical leadership together with public health experts, nonprofit providers, representatives of medically underserved populations and other stakeholders to understand community needs and resources. The assessment process is used to guide the hospital in developing health improvement strategies and making investments that are aligned with priority health issues. It also strengthens relationships among participating organizations.

As in past years, the priorities for community health improvement efforts continue to focus on four broad areas of need specifically for underserved populations:

- Access to health care, including primary and specialty care, and the need for care coordination and case management
- Access to mental health care
- Access to preventative health services and education
- Access to housing/basic shelter

Initiatives that respond to these priority needs are conducted in collaboration with community partners to leverage resources and areas of expertise for higher impact, create a community-wide system of care and foster long-term sustainable change. Such programs, like the WellSpace Health Capacity Expansion Project, the Patient Navigator Program and Healthier Living which addresses chronic disease, are incorporated into the hospital's strategic plan and tied to specific goals and measurable outcomes. Hospital leadership works with community benefit staff to plan, evaluate and budget for these initiatives each year.

Mercy San Juan Medical Center's commitment to the health of its community is reflected through other key programs. Offered each year since 1990, the Dignity Health Community Grants Program is a way for the hospital to support the work of other nonprofit organizations that share the same mission to improve the health and lives of underserved populations. The grants program maintains a focus on the four priority areas of need and further encourages collaboration by requiring organizations to partner on programs in order to provide a greater continuum of care. In the 2014 grants cycle, for example, three organizations joined forces to ensure at-risk individuals were linked to both primary and mental health care, as well as substance abuse treatment and supportive housing if needed. In addition, the Dignity Health Community Investment Program is helping build community capacity by providing loans at below-market rate interest to nonprofit organizations that are working to increase access to health care, create jobs, develop low-income housing, and enhance educational opportunities for underserved populations. This investment opportunity has enabled both WellSpace Health and Elica Health Centers to achieve their designation as Federally Qualified Health Centers, and grow their operations. Providing the means to allow these local health centers to thrive is critical to strengthening the Sacramento region's weak safety net.

Governance

Oversight for community benefit at Mercy San Juan Medical Center is provided by the Dignity Health Sacramento Service Area Community Board. A dedicated Community Health Committee – a standing

committee of the Board – helps guide the hospital’s community benefit practices, ensuring that programs and services address the unmet health needs of the community and promote the broader health of the region (see Appendix A for Dignity Health Sacramento Service Area Community Board and Community Health Committee Rosters). Specific roles and responsibilities of the Community Health Committee are to:

- Ensure services and programs align with the mission and values of Dignity Health and are in keeping with five core principles:
 - Focus on disproportionate unmet health and health-related needs
 - Emphasize prevention
 - Contribute to a seamless continuum of care
 - Build community capacity
 - Demonstrate collaborative governance
- Ensure the hospital follows uniform methods of accounting for community benefit activities and expenses
- Review and approve the Community Health Needs Assessment and ensure alignment of programs and services with priority health issues
- Evaluate and approve the community benefit budget
- Evaluate community benefit program design and content
- Monitor and evaluate program progress, and determine program continuation or termination

Non-Quantifiable Benefits

Recognizing that true health improvement requires shared ownership of strategies and goals, Mercy San Juan Medical Center makes it a responsibility to engage with the community in many ways that are hard to measure and go beyond financial and programmatic investments. Whether serving on coalitions, boards or committees, members of the hospital’s leadership and management teams volunteer significant time and expertise to help develop and implement strategies for long-term positive change in the health, wellbeing and economic vitality of the region. Leadership in the community by the hospital extends to multiple organizations; from Sacramento County’s Medi-Cal Managed Care Advisory Committee, which is focused on improving access, quality and care coordination for Medi-Cal beneficiaries, to Women Escaping a Violent Environment (WEAVE), which strives to end domestic violence and sexual assault. Employees are also actively involved in organizations including the Blue Ribbon Commission for Reducing Infant Mortality among African Americans; Sierra Donor Services; Christo Rey High School; Eskaton; the CARES Foundation; and local chambers and civic organizations.

The hospital maintains its leadership role with the Sacramento Region Health Care Partnership, which was established prior to implementation of the Affordable Care Act by Congresswoman Doris Matsui and Sierra Health Foundation to focus on building safety net capacity. In FY 2014, the partnership launched its Learning Institute, aimed at facilitating an integrated health care delivery model among community clinics and fostering solutions that can improve administrative and service delivery systems.

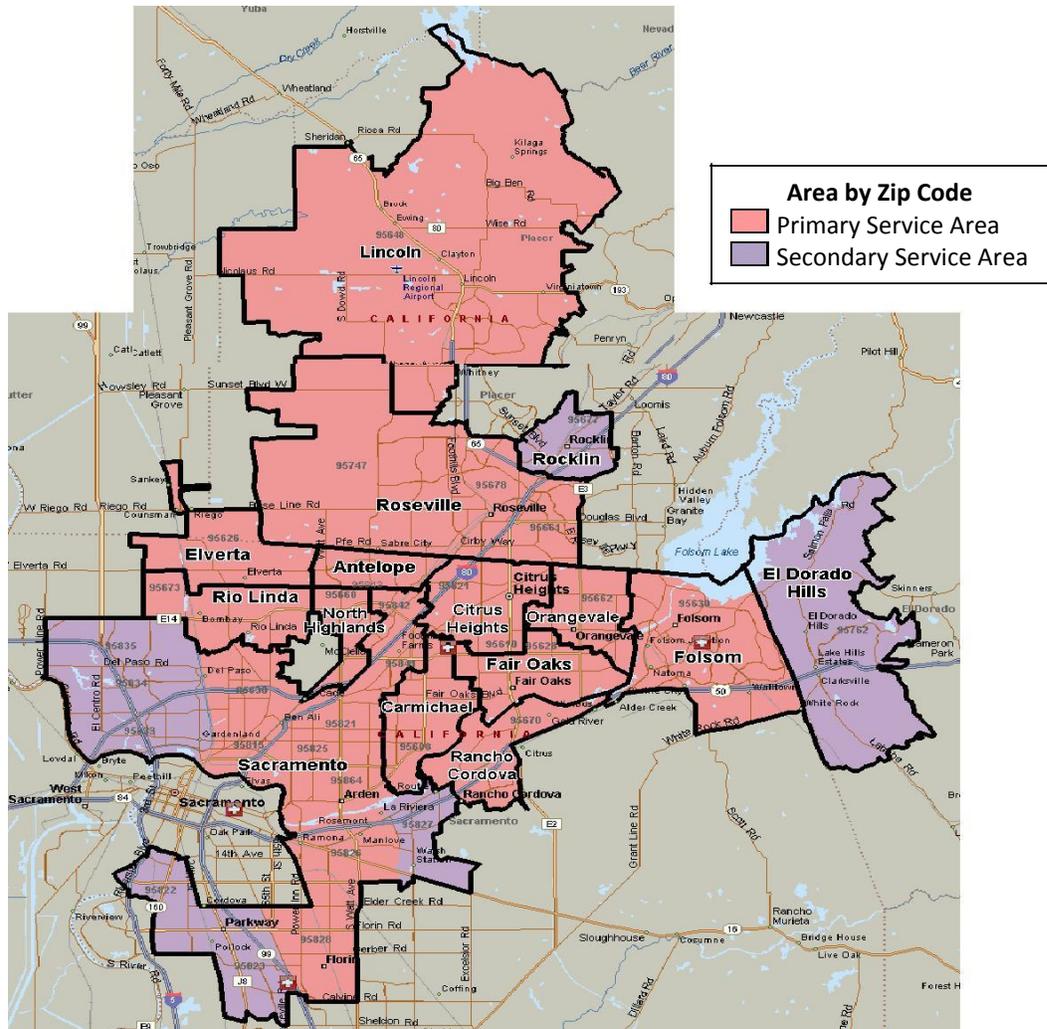
In FY 2014, Mercy San Juan Medical Center and other health systems initiated monthly meetings with Sacramento County leadership to influence actions related to the region’s alarming mental health crisis. These meetings have evolved into the Sacramento County/Regional Hospital Collaborative focused on the development of innovative new strategies for mental health services; some of which hopefully will materialize over the next year.

COMMUNITY

Definition of Community

Mercy San Juan Medical Center's community, or primary service area, in Sacramento County is defined as the geographic area which it serves and determined by analyzing patient discharge data. The hospital's primary service area (shown on the map below) is comprised of 23 zip codes (95608, 95610, 95621, 95628, 95630, 95648, 95660, 95661, 95662, 95670, 95673, 95678, 95747, 95815, 95821, 95823, 95825, 95826, 95838, 95841, 95842, 95843, and 95864). Zip codes, including 95660, 95815, 95821, 95838 and 95841, are designated as Health Professional Shortage Areas by the US Government Health Resources and Services Administration.

Mercy San Juan Medical Center Service Area



Description of the Community

There are over 1.4 million residents living in Sacramento County. Nearly 20% of all residents live below the Federal Poverty Level. A large segment of this underserved population (337,000 residents) is eligible for Medi-Cal insurance under the Affordable Care Act, but unfortunately, having insurance does not equate to having access to care in Sacramento. The region's safety net is ill-prepared to serve this population. There is no

sign that government-funded services that were eliminated during the recession will be reinstated and efforts to build capacity at the community level are only now just beginning to take shape.

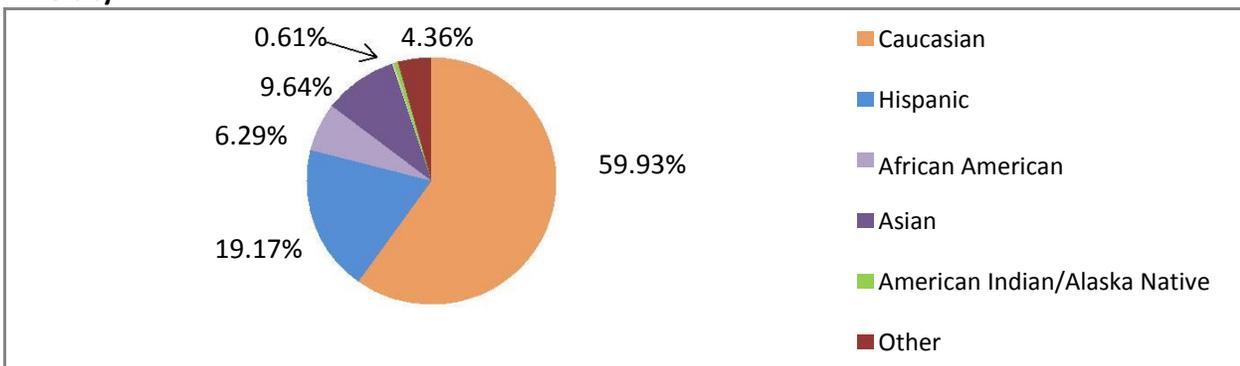
The region continues to be heavily dependent upon Mercy San Juan Medical Center to fill a monumental gap in needed safety net services. There are 66,000 Medi-Cal-insured individuals and families residing within the hospital’s primary service area alone, and a severely limited number of community providers to serve them. The hospital’s utilization trends show that the numbers of underserved individuals turning to the emergency department for basic primary care have tripled over the past five years. These trends align with Community Health Needs Assessment findings surrounding the lack of access to primary care in the community, and underscore the reason why the hospital has selected this issue as a priority area of focus.

Equally, or more concerning, is the serious lack of services and treatment options in the region for the mentally ill. Mercy San Juan Medical Center’s emergency department has become a refuge for individuals in mental crisis. Nearly 3,000 individuals were admitted to the hospital with mental illness in FY 2014; 60% of these admissions involved acute mental illnesses that required inpatient psychiatric care. It was necessary for the hospital to hold these patients in many cases as long as 10 days before treatment facilities could be located, and many residents had to be transferred out of the County in order to receive care. Mercy San Juan Medical Center has taken significant steps to ensure quality of care while patients are in the hospital, and is leading efforts to bring about the broader system change needed to ensure government and community-wide accountability for long term mental health solutions. Until those solutions are instituted, access to mental health care will continue to be a priority area of focus for the hospital.

Demographics of the Community

Mercy San Juan Medical Center’s primary service area encompasses a broad suburban area in the northern portion of Sacramento County and extends into south Placer County. The hospital serves communities including, Citrus Heights, Carmichael, Fair Oaks, North Highlands, and Antelope. There are 929,148 residents living within the hospital’s primary service area. Other demographics include:

Diversity



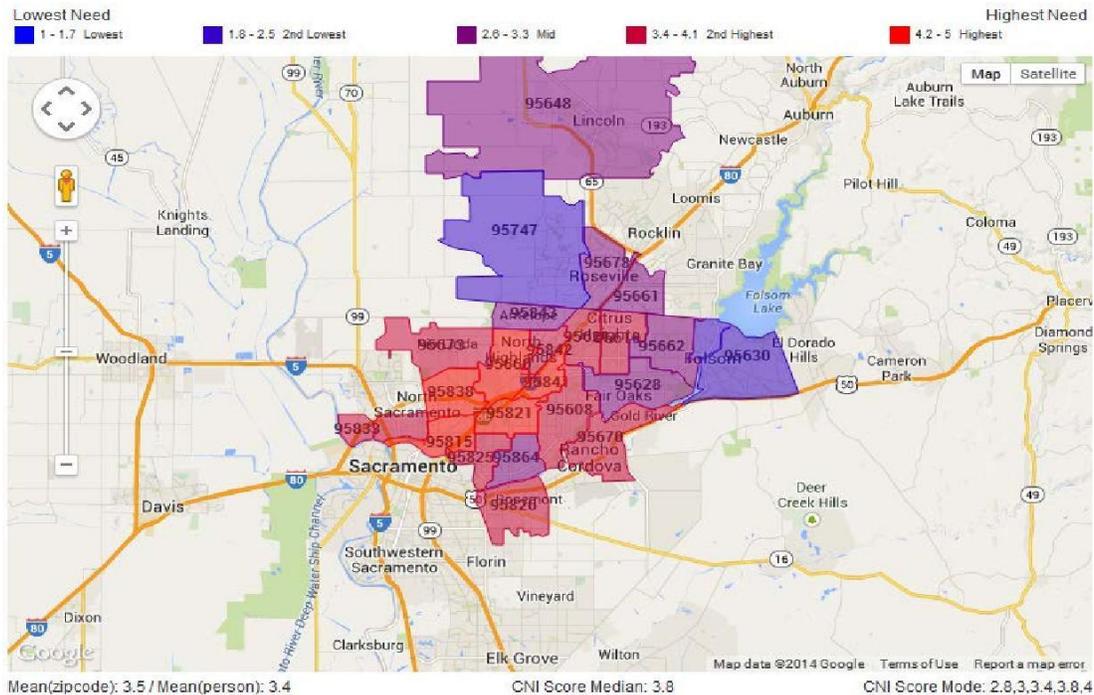
- **Median Income:** \$56,028
- **Uninsured:** 13.01%
- **Unemployment:** 6.9%
- **No High School Diploma:** 11.5%
- **Renters:** 38.1%
- **Community Needs Index (CNI) Score:** 3.8
- **Medicaid Patients:** 17.8%

- **Other Area Hospitals:**
 - Mercy General Hospital
 - Mercy Hospital of Folsom
 - Methodist Hospital of Sacramento
 - Sutter Hospital
 - Kaiser Permanente
 - UC Davis Medical Center
- **Health Professional Shortage Areas:**
 - Zip codes 95660, 95815, 95821, 95838, 95841

Mercy San Juan Medical Center Community Needs Index (CNI) Data

The hospital's CNI Score of 3.8 falls in the second highest range. The CNI highlights by zip code the areas of greatest risk for preventable hospitalizations (see CNI map below). The data is derived from the socio-economic indicators that contribute to health disparities (income, education, insurance, housing and culture/language) and validated by hospital discharge data. Using statistical modeling, the combination of above barriers results in a score between 1 (less needy) and 5 (most needy).

Mercy San Juan Medical Center Community Needs Index (CNI) Map: Median CNI Score: 3.8



Zip Code	CNI Score	Population	City	County	State
95608	3.4	58717	Carmichael	Sacramento	California
95610	3.4	44535	Citrus Heights	Sacramento	California
95621	3.4	38925	Citrus Heights	Sacramento	California
95628	2.8	40353	Fair Oaks	Sacramento	California
95630	2.4	69123	Folsom	Sacramento	California
95648	2.8	57078	Lincoln	Placer	California
95660	4.8	30135	North Highlands	Sacramento	California
95661	3	29551	Roseville	Placer	California
95662	3	29835	Orangevale	Sacramento	California
95670	4	55795	Rancho Cordova	Sacramento	California
95673	3.8	14426	Rio Linda	Sacramento	California
95678	3	44039	Roseville	Placer	California
95747	1.8	52536	Placer County	Placer	California
95815	5	25665	Sacramento	Sacramento	California
95821	4.4	34737	Arden-Arcade	Sacramento	California
95825	4	31566	Sacramento	Sacramento	California
95826	3.8	37846	Rosemont	Sacramento	California
95833	4	36237	Sacramento County	Sacramento	California
95838	4.8	38250	Sacramento	Sacramento	California
95841	4.2	19992	North Highlands	Sacramento	California
95842	3.8	31801	Foothill Farms	Sacramento	California
95843	2.8	48447	Sacramento County	Sacramento	California
95864	2.6	21978	Arden-Arcade	Sacramento	California

COMMUNITY BENEFIT PLANNING PROCESS

Community Health Needs Assessment Process

Mercy San Juan Medical Center completed its most recent Community Health Needs Assessment (CHNA) in spring of 2013, in partnership with nonprofit research organization, Valley Vision, regional health systems, public health experts, Sierra Health Foundation, and California State University, Sacramento. The process engaged multiple community stakeholders over a nine-month period, that in addition to residents, included school district officials, physicians, leaders of community health and social service organizations, and the 70-member Healthy Sacramento Coalition.

Study area for the assessment included the hospital’s primary service area. Zip code boundaries were selected as the unit-of-analysis for most indicators to allow for closer examination of health outcomes at the community level, which are often hidden when viewed at the county level. Some indicators (demographic, behavioral, and environmental in nature) were included in the assessment at the census tract, census block, or point prevalence level, which again, allowed for deeper community level examination. A specific objective was to identify within the hospital’s primary service area, those communities experiencing disparities related to chronic disease and mental health.

The assessment used a mixed methods research approach. Primary qualitative data was obtained from interviews with hospital clinical and community benefit staff members and 31 key informants (area health and community experts). Six focus groups were conducted with area residents, and phone interviews and website analyses were conducted to assess community health assets. Secondary quantitative data was collected on health, demographic, behavioral, and environmental factors. County, state, and Healthy People 2020 targets (when available) were used as benchmarks to determine severity of health issues. Secondary data collected included information on the specific factors shown in Tables 1 and 2.

Table 1: Emergency Department Visits, Hospitalization, Mortality

Emergency Department and Hospitalization		Mortality	
Accidents	Hypertension*	All-Cause Mortality*	Infant Mortality
Asthma	Mental Health	Alzheimer’s Disease	Injuries
Assault	Substance Abuse	Cancer	Life Expectancy
Cancer	Stroke*	Chronic Lower Respiratory Disease	Liver Disease
Chronic Obstructive Pulmonary Disease	Unintentional Injuries	Diabetes	Renal Disease
Diabetes*	Self-inflicted injury	Heart Disease	Stroke
Heart Disease*		Hypertension	Suicide

*Age adjusted by 2010 California standard population

Table 2: Socio-Demographic, Behavioral, and Environmental

Socio-Demographic		Behavioral and Environment	
Total Population	Limited English Proficiency	Major Crime	Percent Obese/Overweight
Family Make-up	Percent Uninsured	Assault	Fruit/Vegetable Consumption
Poverty Level	Percent over 25 No High School	Unintentional Injury	Farmers Markets
Age	Percent Unemployed	Fatal Traffic Accidents	Food Deserts
Race/Ethnicity	Percent Renting	Park Access	Retail Food
Physical Wellbeing Profile			
		Age-Adjusted Mortality	Life Expectancy
		Infant Mortality	Health Care Professional Shortage
		Health Assets	

Identifying Vulnerable Communities

Socio-demographics were examined to identify neighborhoods in the hospital's service area with high vulnerability to chronic disease and mental health. Race/ethnicity, household make-up, income, and age variables were combined into a vulnerability index that described the level of vulnerability within each census tract. This index was then mapped for the entire service area. A tract was considered more vulnerable, or more likely to have poor health outcomes than others, if it had a higher: 1) percent Hispanic or non-White population; 2) percent single parent headed households; 3) percent below 125% of the poverty level; 4) percent under five years old; and 5) percent of individuals 65 years of age or older. This information helped identify areas that required a greater level of examination and discussion with key informants. The vulnerability index for the hospital's service area is shown at right.

Focus Group Selection

Areas selected for focus groups were determined from key informant feedback and through the analysis of health outcome indicators (emergency department visits, hospitalization, and mortality rates). Key informants were asked to identify populations that were most at risk for health disparities and mental health issues. In addition, an analysis of health outcome indicators by zip code, race and ethnicity, age, and sex revealed communities with high rates that exceeded state and county benchmarks and Healthy People 2020 targets.

Communities of Concern

To identify communities of concern, primary data from key informant interviews, and detailed analysis of secondary data, health outcome indicators, and socio-demographics were examined, as well as rates within zip codes that exceeded county, state, or Healthy People 2020 benchmarks for emergency department utilization, hospitalization, or mortality.

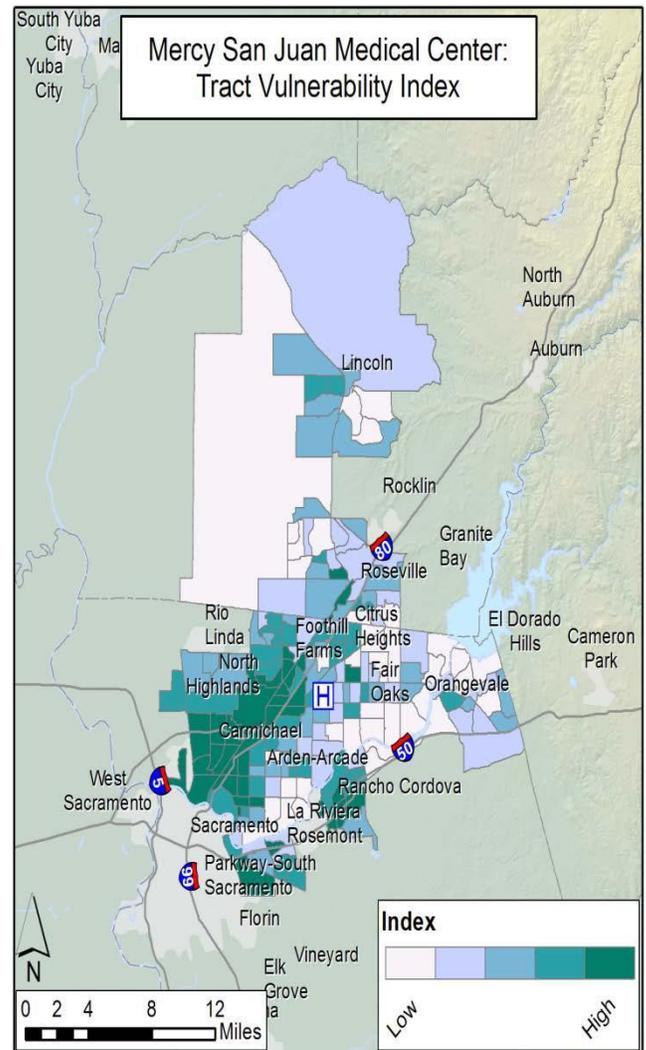
Analysis of data revealed six communities of concern including North Highlands (95660); Rio Linda (95673); south Del Paso Heights, Arden Arcade and north Sacramento communities within 95815; North Watt and Marconi Avenues (95821); Del Paso Heights (95838); and Foothill Farms (95841). These six areas of concern are home to more than 160,000 residents who are highly diverse, have high rates of poverty, low educational attainment, high levels of unemployment, and rent versus

own their homes. There are more single female-headed households and elderly residents 65 years of age or older living in poverty in these areas than the national average.

Priority Health Needs

The assessment identified significant priority health issues across the hospital's primary service area. These health issues were seen in greater magnitude within the communities of concern:

- Lack of access to primary care



- Lack of access to mental health and substance abuse services
- Lack of access to preventative health services
- Lack of access to specialty care
- Lack of access to dental care
- Need for affordable fresh fruits and vegetables
- Need for safe places to be active
- Need for improved transportation services
- Need for cultural competency in providers
- Need for basic shelter

In particular, lack of access to primary and mental health care and lack of access to preventative health services for chronic illness were consistently mentioned in the qualitative phase of the assessment as conditions affecting many area residents.

Communicating the Results

Results of the assessment have been widely disseminated. Forums to examine the findings were conducted within the hospital, and copies of the assessment were made available to local government officials and nonprofit community-based organizations across the region. The assessment is posted on the Dignity Health Website, www.DignityHealth.org (see Attachment 1 for the full report), and also available on the Healthy Living Website (www.healthylivingmap.com), a site developed and provided to the public by Mercy San Juan Medical Center and other health system partners.

Assets Assessment

With the hospital's emphasis on collaborating with partners for more impactful health improvement efforts, gaining a more in-depth understanding of the available resources in the community was an important consideration in the assessment process. Nearly 40 community resources were identified and evaluated. The hospital is currently working with a number of these resources; several others are now being targeted for future partnership initiatives.

Through financial support and partnership programs like the Patient Navigator Program and the Dignity Health Community Grants, the hospital has established strong relationships with local Federally Qualified Health Centers that include WellSpace Health, Elica Health Centers, HALO, Cares Community Health and Health for All. The hospital also works closely with numerous health providers and social service agencies such as WEAVE, iCAN, El Hogar, Sacramento Covered, Salvation Army, Mercy Housing and others on initiatives that address mental health, homelessness, domestic violence, enrollment and health education. New relationships and partnership initiatives are currently being forged with organizations identified through the assets assessment. Mercy San Juan Medical Center will pilot several new programs in FY 2015; among them an innovative housing first model for homeless individuals in partnership with Lutheran Social Services, and a creative mental health navigation program with Turning Point for individuals in mental crisis. A complete listing of community assets within Mercy San Juan Medical Center's primary service area can be found in the Community Health Needs Assessment in Attachment 1.

Implementation Plan Development

In participation with assessment partners, stakeholders and the Dignity Health Community Health Committee, Mercy San Juan Medical Center used the following criteria to evaluate and prioritize community health issues:

1. Magnitude/scale of the problem. The health need emerged consistently through the assessment process as significant and important to a large diverse group of community stakeholders.

2. Severity of the problem. The health need leads to serious effects (co-morbid conditions, mortality and/or economic burden for those affected and the community).
3. Problem linked to high utilization rates. The health need is evidenced by high emergency department and inpatient admissions that could be prevented if adequate resources were available in the community.
4. Internal assets. Mercy San Juan Medical Center has the ability to make a meaningful contribution to respond to the problem through clinical expertise and/or financial resources.
5. Disproportionate impact. The problem disproportionately impacts the health of underserved and vulnerable populations.
6. Evidence-based approaches. There are demonstrated evidence-based practices available that can be applied to effectively address the problem.
7. Assessment trends. The problem consistently emerges as a priority in past assessments.
8. Leveraging resources. There is consensus among stakeholders that the problem is a priority, and there is opportunity to collaborate with others to address the problem.

Through this process of evaluation, four priority health issues were selected from the broader list of priorities identified in the Community Health Needs Assessment as specific areas of focus for the hospital. These include: 1) access to health care, including primary and specialty care, and the need for care coordination and case management; 2) access to mental health care; 3) access to preventative health services and education and; 4) access to housing/basic shelter. Initiatives that address these priorities will target vulnerable and at-risk populations, with emphasis on identified communities of concern and collaboration with other Dignity Health hospitals and community partners to maximize efforts and have a greater region-wide impact. Initiatives will also require methodologies be developed to measure and demonstrate health improvement outcomes. Mercy San Juan Medical Center will continue to work with its partners to refine goals and strategies over time to ensure they effectively address the needs identified.

Implementation Strategies/Actions

1. Access to Health Care (including primary and specialty care, and the need for care coordination and case management)

The Community Health Needs Assessment found there were significant barriers that contribute to poor access to primary health care. While capacity remains a major concern, equally troublesome is the fragmentation that exists within the region's safety net and the lack of attention paid by providers to outreach, education, care coordination, and cultural competency. Confusion about Medi-Cal eligibility, long waits to see a doctor (weeks and often months), and a poor public transportation system present additional barriers to care. Initiatives by the hospital to address the need for increased access to care take these barriers, which are also identified as priority health needs, into consideration. A few of these initiatives are highlighted below.

WellSpace Health Capacity Building Project

Mercy San Juan Medical Center is partnered with sister hospital, Mercy Hospital of Folsom, and WellSpace Health to establish three new full-service community clinics in parts of the region that lack access to primary care. Together, the hospitals have made a \$2.8 million investment to enable WellSpace Health to open three clinics to serve the communities of Rancho Cordova, Citrus Heights/Carmichael and Folsom; areas that lack services. The clinics will significantly increase safety net capacity by providing more than 40,000 new medical homes for underserved residents. The Rancho Cordova clinic has already opened, and in FY 2014 served over 12,500 residents. Additionally, a children's clinic at the Rancho Cordova site served 7,000 children. WellSpace Health's new San Juan clinic in Citrus Heights is slated to open in October 2014. The clinic features 13 primary care exam rooms and six rooms for behavioral health counseling. It is less than two miles away from the hospital, which presents an ideal opportunity for partners to jointly assist patients, coordinate their care and

monitor their health outcomes. WellSpace Health is currently in negotiations for a clinic site in Folsom, and expects to open operations there next year.

Patient Navigator Program

Patient navigators play a key role connecting patients seen and treated at the hospital to medical homes at WellSpace Health, and other community clinics and provider offices throughout the region. The Patient Navigator Program represents a unique collaboration between Mercy San Juan Medical Center and other Dignity Health hospitals in Sacramento, Health Net, a Medi-Cal Managed Care insurance plan, Sacramento Covered, a community-based nonprofit organization, and community clinics in the region. The program targets the uninsured and Medi-Cal -insured who admit to the emergency department for non-urgent (primary care) needs, and aims to increase access to timely, appropriate care in the community, decrease reliance on emergency departments for non-urgent care, and lower cost. In addition to increasing access to care, the program begins to build a much needed system of care coordination within the safety net.

Under the program model, Sacramento Covered navigators are directly stationed in the emergency department and assist patients in a variety of ways that include:

- Scheduling timely follow-up appointments with providers and clinics
- Making connections to social support services
- Providing education on current health plan coverage and/or scheduling for enrollment assistance
- Making referrals into the hospital's chronic disease prevention programs
- Making appointment reminder calls and arranging for transportation if needed
- Following up after appointments to assess satisfaction

Navigators from Sacramento Covered bring special skills to the program, including experience working with the target population, knowledge of the region's clinics and social service agencies, an understanding of the complex Managed Medi-Cal system, and cultural competency. They are also trained to use multiple systems at the hospital, including Mobile MD, a health information exchange system that enables them to communicate in real time with providers and clinics and securely exchange health data.

The program was launched in August 2013. As of August 2014, 4,000 patients have been assisted with a high level of success. Detail on outcomes can be found in the "Description of Key Programs and Initiatives - Program Digests" section of this report.

Sacramento Covered Enrollment Station

In support of the Affordable Care Act, Mercy San Juan Medical Center established a new Medi-Cal Enrollment Station on its campus in FY 2014 to provide assistance during open enrollment primarily for those seeking coverage through Medicaid expansion. This project builds upon the hospital's successful partnership with Sacramento Covered. Through grant funding, Sacramento Covered enrollment specialists staff the station, which is open to the public three days a week, focused on the newly Medi-Cal eligible.

Cancer Nurse Navigator

The Cancer Nurse Navigator program was also introduced by the hospital in FY 2014, to increase access to care for patients with breast cancer. The program is designed to help patients navigate the maze of options related to breast cancer and to complement and enhance services provided by physicians. Nurses provide information, resources and referrals for follow-up biopsies and other treatments that low-income patients otherwise would not be able to access. They provide education, and support both patients and families in dealing with the stresses of being diagnosed with cancer. Nurse navigators also coordinate a peer support volunteer program.

Dignity Health Community Grants Program

Conducted annually by the hospital, the Dignity Health Community Grants Program provides financial support to nonprofit community-based organizations that are focused on increasing access to care, and working collaboratively to provide a continuum of care to vulnerable individuals, families and children.

Mercy Perinatal Recovery Network Transition

Mercy San Juan Medical Center transitioned the Mercy Perinatal Recovery Network (Mercy PRN) to Federally Qualified Health Center, WellSpace Health in FY 2014. Mercy PRN was a small outpatient department of the hospital offering a drug and alcohol recovery treatment program for at-risk pregnant women. Access to these highly specialized services in this capacity was limited. The transition to WellSpace Health provides long-term sustainability for this specialized perinatal program, adds capacity, and expands the scope of services available to the target population. WellSpace Health has substance abuse treatment experience that dates back to 1950, and in addition to a robust perinatal program, offers behavioral health and primary care services at various locations throughout the region.

2. Access to Mental Health Care

Mental illness is perhaps the most pronounced health care problem in the region. Overall care for people with mental illness in the region, rather than improve, has grown worse over the last half decade. Mercy San Juan Medical Center, affiliate Dignity Health hospitals, and other health systems are working together to develop strategies and drive the system change that is needed to address this region's mental health crisis. Partners began meeting monthly with Sacramento County leadership in FY 2014 to better understand County mental health care obligations, share utilization trends and play a role in shaping plans for future services that are considered critical to addressing the issue. The hospital also continues its leadership role on the Community Mental Health Partnership, convened by the Hospital Council of Northern & Central California, and continues to evaluate new internal initiatives and external partnerships to improve quality of care for the mentally ill.

ReferNet Intensive Outpatient Mental Health Partnership

ReferNet is a highly promising mental health initiative being conducted in partnership with community-based nonprofit mental health provider El Hogar. The program provides a seamless way for individuals admitting to the emergency department with mental illness to receive immediate and ongoing intensive outpatient treatment and other social services they need for a continuum of care when they leave the hospital. Emphasis is on the underserved who otherwise would not have access to mental health care. There were 243 individuals successfully linked to care through this partnership in FY 2014.

Navigation to Wellness Program

Starting in FY 2015, clinicians and peer support specialists from Turning Point will be working side by side with emergency department staff at Mercy San Juan Medical Center to link mentally ill patients to appropriate public and community behavioral health services needed for wellness. The program targets underserved individuals who may be unaware of available services. Turning Point has provided a path to mental health for residents in the region since 1976, and can share with the hospital its best practice approaches to mental health care. Emergency department staff will be trained to better identify individuals who are in need of additional community support services, and to identify which services are most suitable for specific individuals.

Mental Health Consultations and Conservatorship Services

The hospital continues to provide psychiatric consultations at no cost for all patients who require evaluations while hospitalized, as well as patient conservatorship services to those who lack capacity or family help to make decisions. These services were provided to nearly 3,000 individuals in FY 2014.

3. Access to Preventative Health Services and Education

Chronic disease was consistently mentioned in the 2013 Community Health Needs Assessment as a condition affecting a large number of residents, and has been identified as such in all past assessments. Assessment participants described the lack of available education and support services as major barriers to staying healthy, leading normal lives, and keeping their costs for health care in check. An inability for individuals to manage their chronic disease is also a cause for high emergency department readmission rates. Mercy San Juan Medical Center, in partnership with other Sacramento area Dignity Health hospitals, offers the only community-based chronic disease specific health prevention and education programs available.

Healthier Living

Mercy San Juan Medical Center continues to expand its Chronic Disease Self-Management and Diabetes Self-Management Program, Healthier Living, which follows the evidence-based Stanford University School of Medicine model. The program is taught in both English and Spanish and designed to provide participants who have chronic diseases with the knowledge, tools and motivation needed to become proactive in their health. Healthier Living workshops target the underserved and are offered in both clinical and community settings, like low-income housing developments in partnership with Mercy Housing, at community clinics, food banks and other locations that provide easy access for participants. Consistently, more than 80% of all who complete the workshops are able to successfully increase their self-efficacy and avoid hospitalization. In FY 2014, 18 new community volunteers were trained as program “Master Trainers,” which builds significant capacity in the community for carrying the program forward.

CHAMP®

CHAMP® (Congestive Heart Active Management Program) provides support and assistance to those who suffer from heart failure and disease. The program keeps individuals linked to the medical world once they leave the hospital through symptom and medication monitoring and education. Consistently, the program achieves an 80% or better reduction in hospital readmissions by participants each year. The hospital’s CHAMP® team has moved into the community as well, partnering with Mercy Housing, community clinics and other organizations to provide education and health screenings to low-income residents.

Safe Kids

Mercy San Juan Medical Center teams with law enforcement, fire fighters, other providers and community members to raise public awareness about health and safety for children through the Safe Kids program. The program is operated out of Mercy San Juan Medical Center’s Trauma Prevention Program, and features outreach and education to parents, caregivers and children to prevent serious injury and deaths from car accidents. A primary focus for the program is the appropriate use of car seats, and if parents or caregivers do not have or cannot afford a car seat, Mercy San Juan Medical Center makes sure they receive one at no cost. The hospital particularly targets these services for families and children living in poverty, and members of the non-English speaking Hispanic, Russian and Hmong communities where the need is greatest.

1. Access to Housing/Basic Shelter

Sacramento has been referred to as ground zero for California’s homeless crisis¹. Although the size of its homeless population does not compare to larger cities in the State, its high foreclosure rates during the recession led hundreds of people to the streets or to live in their cars. In 2009, government officials revealed a long-term strategy to end homelessness involving new pathways to permanent housing, case management, job training and transitional safety net services. Since then, however, the numbers of homeless women and children has only increased. Today, the estimated number of homeless individuals in the region approaches

¹ Baram, M. (2/9/2013). *California Crisis Grows as State is Reluctant to Use Powerful Law*. Huffington Post.

3,000, up by several hundred just since 2011². With nearly 300 hospitalizations annually by homeless individuals who most often have acute medical needs, no family, no shelter and no means of support, Mercy San Juan Medical Center experiences the urgency of this problem first hand. The hospital is working with community leaders and homeless advocates to build capacity in the community to ensure this population has access to resources and services. The hospital also began work on two homeless initiatives in FY 2014 that will be launched in FY 2015.

Housing First Homeless Program

In partnership with Lutheran Social Services, Mercy San Juan Medical Center will pilot a Housing First Homeless Program in FY 2015 that aims to assist homeless individuals with severe chronic health and mental health issues in obtaining and retaining housing, care and services designed to achieve stability in their lives. Hospital case managers will work directly with Lutheran social services staff to identify participants who will be housed in supportive living apartments and receive intensive case management and supportive services. Ongoing health care for these participants will be provided by the Mercy Family Health Center and Mercy Home Care, with the goal of transitioning participants into permanent housing. Lutheran Social Services has a strong track record of success in serving those that are hardest to serve because of the length of time that many individuals have been homeless and the severity of their disabilities. A hospital core team and Lutheran Social Services will meet quarterly and work together to monitor and track the progress of participants.

Homeless Outreach Project

Development also began in FY 2014 for a new Homeless Outreach project in partnership with Sacramento Steps Forward, Sacramento Loaves & Fishes, and the Downtown Sacramento Foundation. A network of navigators from the Downtown Sacramento Partnership will outreach to the most vulnerable chronically homeless individuals on the street or in the emergency department with the intent to connect them to supportive services, mental health care and appropriate housing placement options. The collaboration will pioneer the use of an integrated coordinated assessment tool and central intake center. The hospital emergency department will be linked to navigators as well as the central intake center.

Interim Care Program (ICP)

Mercy San Juan Medical Center continues to support and take an active role in the Interim Care Program (ICP). This collaborative engages other Dignity Health hospitals and health systems in the region, the Salvation Army, Sacramento County and WellSpace Health, and provides a respite care shelter for homeless patients who are ready to be discharged from the hospital but have no family or means of support. In addition to safe shelter, the ICP offers follow-up physical health care, mental health care and substance abuse treatment, enrollment services for public programs, and case management services.

Needs Not Prioritized

Mercy San Juan Medical Center responds to the health needs of its community in many ways, and in times that are critical for those in crisis. In addition to financial assistance, indigent care, and un-funded Medi-Cal care, a significant investment is being made to address the four priority health needs outlined in this report. While Mercy San Juan Medical Center has focused on these priority areas, this report is not exhaustive of everything the hospital does to enhance the health of its community. However, the needs in Sacramento County are monumental and Mercy San Juan Medical Center does not have the available resources to develop and/or duplicate efforts to meet them all. The hospital is not directly addressing dental care, or the need for healthy foods. First 5 Sacramento Commission, WellSpace Health, Health and Life Organization, and the Sacramento District Dental Society are providing dental care. Kaiser Permanente is addressing the need for healthy foods

² Sacramento Steps Forward (2013). Sacramento County Homeless Count Report

through its Healthy Eating Active Living (HEAL) Program. Mercy San Juan Medical Center has, and will continue, to provide support to enhance these efforts. The hospital will also continue to seek collaboration opportunities that address needs that have not been selected where it can appropriately contribute to addressing those needs.

Planning for the Uninsured/Underinsured Patient Population

Mercy San Juan Medical Center strives to ensure that the needs of the uninsured and underinsured patient population are addressed. No one should go without health care and the hospital is committed to treating patients who have financial needs with the same dignity, compassion and respect that is extended to all patients. The hospital considers each patient's ability to pay for his or her medical care, and follows the Dignity Health Patient Payment Assistance Policy, which makes free or discounted care available to uninsured individuals with incomes up to 500% of the federal poverty level (see Appendix B for a summary of the Dignity Health Patient Payment Assistance Policy).

Continued education to stay current on the Financial Assistance Policy is required for hospital leadership and employees at all levels of the organization. Employees working in Admitting and Patient Financial Services are fully versed in the policy and dedicated to assisting patients that are in need of support. Any employee or member of the medical staff can refer patients for financial assistance. Family members, friends or associates of a patient may also make a request for financial assistance.

To ensure all patients are aware of the policy, financial assistance information is distributed in a number of ways. Notices in the primary languages spoken by the populations the hospital serves are posted in the emergency department, in admitting and registration areas, and in the business and financial services office. Notices are also placed in all patient bills and include a toll-free contact number.

In addition to financial assistance, the hospital further supports the specific needs of uninsured and underinsured patient populations by providing prescription medications, transportation, mental health consultations and conservatorship services at no cost. For years, Mercy San Juan Medical Center has provided enrollment assistance for the underserved. These efforts were enhanced in FY 2014 to support implementation of the Affordable Care Act. The hospital hosted numerous enrollment fairs in the community in partnership with community-based nonprofit Sacramento Covered to provide assistance during open enrollment to those seeking coverage through the Health Benefit Exchange and Medicaid expansion.

PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Summary of Key Programs and Initiatives

Key community benefit initiatives and community-based programs directly provided, or substantially supported, by Mercy San Juan Medical Center in FY 2014 are summarized below. These initiatives and programs are mapped to align with the four priority health areas identified in the Community Health Needs Assessment and are guided by five core principles:

1. Focus on disproportionate unmet health-related needs
2. Emphasize prevention
3. Contribute to a seamless continuum of care
4. Build community capacity
5. Demonstrate collaborative governance

Initiative I: Access to Health Care (including primary and specialty care, and the need for care coordination and case management)

- Financial assistance
- WellSpace Health Capacity Building Project
- Patient Navigator Program
- Sacramento Covered Enrollment Station (new in FY 2014)
- Cancer Nurse Navigator (new in FY 2014)
- SPIRIT Specialty Referral Program
- Dignity Health Community Grants Program
- Dignity Health Community Investment Program
- School Health Nurse Program
- Charity prescriptions
- Community health screenings
- Transportation
- Healthy Kids Day
- Participation in Sacramento Region Health Care Partnership
- Participation in Sacramento County Medi-Cal Managed Care Advisory Committee

Initiative II: Access to Mental Health Care

- ReferNet Intensive Outpatient Mental Health Partnership
- Navigate to Wellness (currently developing this new partnership program with Turning Point for implementation in FY 2015)
- Mental health consultations and conservatorship services
- Financial support to private psychiatric treatment facilities to cover cost of uninsured patients
- Mobile Crisis Team
- Participation in the Sacramento County/ Regional Hospital Collaborative
- Participation in Community Mental Health Partnership

Initiative III: Access to Preventative Health Services and Education

- Healthier Living (Chronic Disease Self-Management/Diabetes Self-Management Programs)
- CHAMP® (Congestive Heart Active Management Program)
- Participation in American Diabetes Association
- Safe Kids Program

- Mercy Faith and Health Partnership

Initiative IV: Access to Housing/ Basic Shelter

- Interim Care Program (ICP)
- Homeless Housing First Program (completed development in FY 2014 for start-up in FY 2015 in partnership with Lutheran Social Services)
- Homeless Outreach Project (development began in FY 2014; program will launch in FY 2015 in partnership with Sacramento Steps Forward, Sacramento Loaves & Fishes, and the Downtown Sacramento Foundation)
- Transitional housing and lodging

These key programs are continuously monitored for performance and quality with ongoing improvements to facilitate their success. The Dignity Health Sacramento Service Area Community Board and Community Health Committee, hospital leadership, and Dignity Health receive updates on program activities and outcomes. The following pages include Program Digests for key programs that address one or more of the initiatives listed above.

DESCRIPTION OF KEY PROGRAMS AND INITIATIVES - PROGRAM DIGESTS

PATIENT NAVIGATOR PROGRAM

Hospital Priority Areas	<ul style="list-style-type: none"> ✓ Access to Health Care ☐ Access to Mental Health Care ✓ Access to Preventative Health Services and Education ✓ Access to Housing/Basic Shelter
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ☐ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to CHNA Vulnerable Population	Access to primary care and the difficulty in navigating the safety net system are priority issues. The need for patient navigation and assistance is evident in the high Emergency Department (ED) utilization rates by Medi-Cal-insured and uninsured patients for non-urgent care (30% of all visits). This trend is increasing with ACA expansion.
Program Description	The program is a collaborative initiative between the hospital, Health Net, Sacramento Covered and community health centers. It uses health information technology (MobileMD) and shared case management support to assist patients who rely on EDs for non-urgent needs because they are unable to navigate a fragmented safety net by connecting them to a medical home in an appropriate setting.

FY 2014

Goal FY 2014	Assist underserved patients admitting to the EDs for primary care in finding medical homes in an appropriate community clinic setting or reconnecting them with their assigned Primary Care Provider (PCP) and other social support services to reduce their reliance on EDs, improve their health and lower cost.
2014 Objective Measure/Indicator of Success	Over 50% of all ED visits are for primary care and could be avoided if care was received in a physician's office or clinic. The program is measured by improved access for patients, reduced ED primary care visits, and reduced cost.
Baseline	Access to primary care is a priority CHNA health issue resulting in high utilization of the ED for basic care.
Intervention Strategy for Achieving Goal	Weekly/monthly meetings to trouble shoot, track progress, etc. with navigators, partners and ED program teams.
Result FY 2014	Assisted 931 patients in FY 2014 (scheduling follow up appointments at PCP for over 80%). Reduction of non-urgent usage by 52% and urgent care by 47% across all hospitals for population served.
Hospital's Contribution / Program Expense	\$127,128

FY 2015

Goal 2015	Assist underserved patients admitting to the EDs for primary care in finding medical homes in an appropriate community clinic setting or reconnecting them with their assigned PCP and other social support services to reduce their reliance on EDs, improve their health and lower cost.
2015 Objective Measure/Indicator of Success	Over 50% of all ED visits are for primary care and could be avoided if care was received in a physician's office or clinic. Program will be measured by improved access for patients; reduced ED primary care visits; and reduced cost.
Baseline	Access to primary care is a priority CHNA health issue resulting in high utilization of the ED for basic care.
Intervention Strategy for Achieving Goal	Weekly/monthly meetings to trouble shoot, track progress, etc. with navigators, partners and ED program teams.
Community Benefit Category	A3-e Health Care Support Services – Information & Referral.

HEALTHIER LIVING CHRONIC DISEASE SELF-MANAGEMENT PROGRAM (CDSMP)

Hospital Priority Areas	<input type="checkbox"/> Access to Health Care <input type="checkbox"/> Access to Mental Health Care <input checked="" type="checkbox"/> Access to Preventative Health Services and Education <input type="checkbox"/> Access to Housing/Basic Shelter
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to CHNA Vulnerable Population	Chronic disease is identified as a priority health issue in the current and past CHNAs. The program specifically targets underserved residents who otherwise lack access to health prevention and education.
Program Description	Following the evidence-based Stanford model, Healthier Living provides residents with chronic diseases (emphasis on Diabetes) knowledge, tools and motivation needed to become proactive with their health.
FY 2014	
Goal FY 2014	Provide education and skills to help those with chronic disease manage their symptoms and lead healthier and more productive lives; thus reducing their need to admit to the hospital. Specifically, achieve maximum target metric goal or better – 70% of all participants avoid admission three months post intervention.
2014 Objective Measure/Indicator of Success	Continue to meet/exceed metric goal. Develop new lay leaders and community partners in order to expand workshop offerings and participants. Seek further collaboration to expand program throughout the community.
Baseline	Chronic disease, including, heart disease, diabetes, stroke, asthma and cancer plagues the region and accounts for high ED and inpatient admissions. Chronic disease is identified as a priority CHNA health issue.
Intervention Strategy for Achieving Goal	Outreach to the community clinics and other nonprofits. Continue to build community partnerships for expansions of workshops. Continue to identify community lay leaders. Develop partnerships for growth.
Result FY 2014	19 CDSMP and Diabetes workshops were conducted in both English and Spanish with a total of 191 participants completing the program. Less than 12% of the participant admitted to the hospital within three months of completing the workshop. There are now 20 active lay leaders, 4 of whom are Spanish speaking. 18 new Master Trainers were trained.
Hospital's Contribution / Program Expense	\$16,639
FY 2015	
Goal 2015	Provide education and skills management to help those with chronic disease manage their symptoms and lead healthier and more productive lives; thus reducing their need to admit to the Hospital. Specifically, achieve maximum target metric goal or better – 70% of all participants avoid admission three months post program intervention.
2015 Objective Measure/Indicator of Success	Continue to meet/exceed metric goal. Develop new lay leaders and community partners to expand workshop offerings at community clinics and other agencies; increase the number of participants.
Baseline	Chronic disease is identified as a priority health issue in the current and past CHNAs.
Intervention Strategy for Achieving Goal	Outreach to the community clinics and other nonprofits. Continue to build community partnerships for expansions of workshops. Continue to identify community lay leaders and partnerships for growth.
Community Benefit Category	A1-a Community Health Education – Lectures/Workshops.

CONGESTIVE HEART ACTIVE MANAGEMENT PROGRAM (CHAMP®)

Hospital Priority Areas	<ul style="list-style-type: none"> ✓ Access to Health Care ☐ Access to Mental Health Care ✓ Access to Preventative Health Services and Education ☐ Access to Housing/Basic Shelter
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate unmet health-related needs ✓ Primary prevention ✓ Seamless continuum of care ✓ Build community capacity ✓ Collaborative governance
Link to CHNA Vulnerable Population	The regional program responds to a priority health need identified in the CHNA. Heart failure is a leading cause of hospitalization for residents throughout the broader Sacramento region. It is the fifth highest reason for emergency department visits, and the number one cause of death.
Program Description	<p>CHAMP® establishes a care relationship with patients who have heart disease after discharge from the hospital through:</p> <ul style="list-style-type: none"> - Regular phone interaction; support and education to help manage this disease. - Monitoring of symptoms or complications and recommendations for diet changes medicine modifications or physician visits.

FY 2014

Goal FY 2014	Improve the health and quality of life of those who suffer from heart disease, enabling them to better manage their disease and reducing their need to be admitted or readmitted to the hospital.
2014 Objective Measure/Indicator of Success	Continue to increase enrollment of underserved through outreach and community collaboration, and maintain reduction in number of hospitals admissions and readmissions for enrolled participants.
Baseline	Heart failure is a priority health issue for the region, identified in past and current CHNAs. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease.
Intervention Strategy for Achieving Goal	Regular meetings with CHAMP® Teams at hospitals; continued partnership building with FQHCs.
Result FY 2014	4,488 patients served across the four Dignity Health hospitals in Sacramento and less than 2% of the patients served returned to the Emergency Department three months post intervention.
Hospital's Contribution / Program Expense	\$417,098 which is a shared expense by Dignity Health hospitals in Sacramento County.

FY 2015

Goal 2015	Improve the health and quality of life of those who suffer from heart disease, enabling them to better manage their disease and reducing their need to be admitted or readmitted to the hospital.
2015 Objective Measure/Indicator of Success	Continue to increase enrollment by the underserved through outreach and community collaboration, and maintain reduction in number of hospital admissions and readmissions for participants. Strengthen collaboration between CHAMP and Patient Navigator Program and the hospital's Readmission Committees to increase referrals.
Baseline	Heart failure is a priority health issue for the region, identified in past and current CHNAs. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease.
Intervention Strategy for Achieving Goal	Regular meetings with CHAMP® Teams at hospitals; continued partnership building with FQHCs connecting heart failure patients to a medical home.
Community Benefit Category	A2-e community based clinical services – ancillary/other clinical services.

INTERIM CARE PROGRAM (ICP) and ICP+ PROGRAM

Hospital Priority Areas	<ul style="list-style-type: none"> ✓ Access to Health Care ✓ Access to Mental Health Care ✓ Access to Preventative Health Services and Education ✓ Access to Housing/Basic Shelter
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to CHNA Vulnerable Population	The Interim Care Program (ICP) responds to the growing number of homeless individuals who lack of access to care; a CHNA priority health issue. The program also addresses the high hospital utilization rates by this population due to lack of adequate services.
Program Description	ICP is a partnership with Mercy San Juan Medical Center, sister Dignity Health Hospitals, other health systems, Sacramento County and WellSpace Health (FQHC). It provides homeless men and women a safe environment for recovery when they are ready to be discharged from the hospital. Participants receive mental health care, substance abuse treatment and social services support to transition to a healthier lifestyle. ICP+ is a 5-bed skilled nursing unit Dignity Health hospitals support to add needed capacity.

FY 2014

Goal FY 2014	Increase access to a continuum of care and social support services to meet the special needs of homeless individuals necessary to improve their health status and reduce their need to admit to the hospital.
2014 Objective Measure/Indicator of Success	Increase number of successful ICP and ICP+ referrals; evaluate the need/utilization of the ICP+ 5-bed unit.
Baseline	ICP responds to the growing number of homeless individuals and lack of access to care; a CHNA priority health issue. The program also addresses the high hospital utilization rates by this population.
Intervention Strategy for Achieving Goal	Meetings and ongoing check-ins with hospital Case Management teams and tour of ICP facility; quarterly ICP oversight committee meetings; develop hospital internal methodology for measuring outcomes.
Result FY 2014	67 persons served, with measures of success, including 15 persons in the 5-bed skilled nursing unit (ICP+); 440 days were spent by homeless clients in the 5-bed Mercy unit alone, which otherwise would have been days spent in hospital. Upon evaluation, the hospital is considering a new pilot housing first model in FY 2015, which would replace the 5-bed ICP+ unit, which is not addressing the need for permanent housing.
Hospital's Contribution / Program Expense	\$243,232 which is a shared expense by Dignity Health Hospitals in Sacramento.

FY 2015

Goal 2015	Increase access to a continuum of care and social support services to meet the special needs of homeless individuals necessary to improve their health status, and reduce their need to admit to the hospital.
2015 Objective Measure/Indicator of Success	Increase number of successful ICP/ICP+ referrals; new housing first pilot to replace for 5-bed ICP+ unit.
Baseline	ICP responds to the growing number of homeless individuals and lack of access to care, a CHNA priority health issue. The program also addresses the high hospital utilization rates by this population.
Intervention Strategy for Achieving Goal	Continue to work with staff to improve reporting of deliverables and quarterly tracking of outcomes. Ongoing check-ins and referral trainings with Case Management; quarterly ICP oversight meetings.
Community Benefit Category	E1-a Financial Donations - General contributions to nonprofit organizations/Community Groups

SAFE KIDS

Hospital Priority Areas	<input type="checkbox"/> Access to Health Care <input type="checkbox"/> Access to Mental Health Care <input checked="" type="checkbox"/> Access to Preventative Health Services and Education <input type="checkbox"/> Access to Housing/Basic Shelter
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to CHNA Vulnerable Population	Safe Kids responds to the need for injury prevention and health and safety education for families in lower income communities who lack access to these services. Free infant and child car seats are also offered in addition to education. The hospital also leads the coalition of partners engaged in infant and child safety.
Program Description	Infant and child car seat and health/safety education classes are provided at no cost to families with children living in poverty and to families with children in immigrant communities, where the need is greatest. Safe Kids health and safety fairs are part of the overall program. These offer a venue to provide safety education to parents, care-givers and children in the community. The hospital is the only provider offering car seat education to the largest non-English speaking populations in the region – Hispanic, Russian and Hmong.

FY 2014

Goal FY 2014	Improve the public awareness of child safety and provide education for families living in poverty and immigrant communities to prevent infant and child injury and death from auto accidents.
2014 Objective Measure/Indicator of Success	Continue to lead a coalition of over 30 local agencies, including hospitals, fire, police, state and county agencies devoted to preventing childhood injury and death. Continue to offer classes/educational opportunities and car seat checks in areas of need.
Baseline	Based on the needs of the community, the coalition implements evidence-based programs, such as car-seat checkups and safety workshops to assist parents and caregivers in preventing childhood injuries.
Intervention Strategy for Achieving Goal	Conduct regular coalition meeting and provide outreach, education and resources to targeted communities.
Result FY 2014	5,450 community members served; 602 car seat checks; distribution of 284 car seats.
Hospital's Contribution / Program Expense	\$215,705

FY 2015

Goal 2015	Improve the public awareness of child safety and provide education workshops for families living in poverty and immigrant communities.
2015 Objective Measure/Indicator of Success	Continue to lead a coalition of over 30 local agencies, including hospitals, fire, police, state and county agencies devoted to preventing childhood injury and death. Continue to offer classes/educational opportunities and car seat checks in areas of need.
Baseline	Based on the needs of the community, the coalition implements evidence-based programs, such as car-seat checkups and safety workshops to assist parents and caregivers in preventing childhood injuries.
Intervention Strategy for Achieving Goal	Conduct regular coalition meeting and provide outreach, education and resources to targeted communities.
Community Benefit Category	A1-a Community Health Education - Lectures/Workshops

CANCER NURSE NAVIGATOR

Hospital Priority Areas	<ul style="list-style-type: none"> ✓ Access to Health Care ✓ Access to Mental Health Care ✓ Access to Preventative Health Services and Education ☐ Access to Housing/Basic Shelter
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ☐ Collaborative Governance
Link to CHNA Vulnerable Population	Lack of preventative and specialty care is a priority health issue for the region, identified in past and current CHNAs. The program demonstrate improvements in the health of participants while offering services free of cost that would not otherwise be accessible.
Program Description	This program provides continuity of care, enhancing patient/doctor communication whenever an abnormality shows up on mammogram, breast ultrasound, or breast MRI, as well as information to the community about financial assistance for breast cancer screening. Patients receive information, resources, and support for assisting with biopsies. Education about pathology results and assistance obtaining referrals to specialists is provided in a timely manner. The navigators also coordinate a group of peer support volunteers who are matched up with patients newly diagnosed with breast cancer.

FY 2014

Goal FY 2014	Ensure timely access to treatment and related resources for those with cancer, with emphasis on the underserved who otherwise cannot afford care and improve patient/doctor relationships.
2014 Objective Measure/Indicator of Success	Continue to increase the number of underserved assisted through outreach and community collaboration and build awareness of the program among community partners.
Baseline	Services and resources for specialty care, especially cancer, continue to be identified as a priority in the CHNA. The program offers resources that would otherwise not be accessible to the underserved.
Intervention Strategy for Achieving Goal	Promote services in the community and work with hospital and community partners to increase awareness of services and resources; this includes working with patient navigators who are located in the ED's.
Result FY 2014	2589 persons served -- shared by Dignity Health hospitals in Sacramento and Yolo counties.
Hospital's Contribution / Program Expense	\$68,855 -- shared by Sacramento and Yolo County Dignity Health Hospitals

FY 2015

Goal 2015	Ensure timely access to treatment and other resources for those with cancer, with emphasis on the underserved who otherwise cannot afford care, and Improve patient/doctor relationships.
2015 Objective Measure/Indicator of Success	Continue to increase number of underserved assisted through outreach and community collaboration and build awareness of the program among community partners.
Baseline	Services and resources for specialty care, especially cancer, continue to be identified as a priority in the CHNA. The program offers necessary resources that would otherwise not be accessible for Medi-Cal and uninsured populations.
Intervention Strategy for Achieving Goal	Promote services in the community and work with hospital and community partners to increase awareness of services and resources; this includes working with patient navigators who are located in the ED's.
Community Benefit Category	A3-e Health Care Support Services – Information & Referral.

This implementation strategy specifies community health needs that the hospital has determined to meet in whole or in part and that are consistent with its mission. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the years ending December 31, 2015, other organizations in the community may decide to address certain needs, indicating that the hospital should then refocus its limited resources to best serve the community.

COMMUNITY BENEFIT AND ECONOMIC VALUE

The following FY 2014 (for period from 7/1/2013 through 6/30/2014) Classified Summary of Un-sponsored Community Benefit Expense for Mercy San Juan Medical Center was calculated using a cost accounting methodology.

Benefits for Those Living In Poverty	Persons Served	Total Expenses	Offsetting Revenue	Net Benefit	% of Organization Expenses	% of Organization Revenues
Financial Assistance	1,678	3,860,545	0	3,860,545	0.7	0.7
Medicaid Means-Tested Programs	48,020	167,843,110	123,939,806	43,903,304	8.3	7.9
Community Services	657	5,266,350	2,858,439	2,407,911	0.5	0.4
Community Benefit Operations	0	108,441	0	108,441	0	0
Community Building Activities	0	2,536	0	2,536	0	0
Community Health Improvement Services	7,579	1,094,964	141,315	953,649	0.2	0.2
Financial and In-Kind Contributions	270	1,443,462	0	1,443,462	0.3	0.3
Subsidized Health Services	3,330	1,574,465	41,039	1,533,426	0.3	0.3
Totals for Community Services	11,179	4,223,868	182,354	4,041,514	0.8	0.7
Totals for Those Living In Poverty	61,534	181,193,873	126,980,599	54,213,274	10.2	9.8

Benefits for the Broader Community	Persons Served	Total Expenses	Offsetting Revenue	Net Benefit	% of Organization Expenses	% of Organization Revenues
Community Services						
Community Building Activities	13	7,419	0	7,419	0	0
Community Health Improvement Services	2,389	37,650	90	37,560	0	0
Financial and In-Kind Contributions	4	824,803	0	824,803	0.2	0.1
Totals for Community Services	2,406	869,872	90	869,782	0.2	0.2
Totals for the Broader Community	2,406	869,872	90	869,782	0.2	0.2

Totals - Community Benefit	63,940	182,063,745	126,980,689	55,083,056	10.4	10
Unpaid Cost of Medicare	48,303	146,301,582	129,828,883	16,472,699	3.1	3
Totals with Medicare	112,243	328,365,327	256,809,572	71,555,755	13.5	12.9
Grand Totals	112,243	328,365,327	256,809,572	71,555,755	13.5	12.9

TELLING THE STORY

Effectively telling the community benefit story is essential to creating an environment of awareness, understanding and interest in the priority health issues challenging the region and importantly, to inform the public about the ways in which these issues are being addressed by Mercy San Juan Medical Center. The 2014 Community Benefit Report and 2015 Community Benefit Implementation Plan will be distributed to hospital leadership, members of the Community Board and Community Health Committee, and widely to management and employees of the hospital. It serves as a valuable tool for ongoing community benefit awareness and training.

The document will also be broadly distributed externally to Community Health Needs Assessment partners, community leaders, government and public health officials, program partners and other agencies and businesses throughout the region. It can be found, along with the 2013 Community Health Needs Assessment, under “Community Health” in the “Who We Are” section on Dignity Health’s Website: www.DignityHealth.org. It will also be available on the Healthy Living Website (www.healthylivingmap.com), a site developed and provided to the public by Mercy San Juan Medical Center and other health system partners.

APPENDIX A

Dignity Health Sacramento Service Area Community Board Roster

Sister Brenda O’Keeffe, Chair Vice President, Mission Integration Mercy Medical Center Redding	Sister Patricia Simpson, O.P.
Glennah Trochet, MD, Vice Chair Retired Sacramento County Public Health Officer Community Representative	Nancy Appelblatt, MD Chief of Staff Mercy General Hospital
Brian King, Secretary Los Rios College District Chancellor	Jeff Anderson, MD Chief of Staff Mercy Hospital of Folsom
Gil Albiani Real Estate Community Representative	Robert Kahle, MD Chief of Staff Mercy San Juan Medical Center
Julius Cherry Attorney Community Representative	Robert Kozel, MD Chief of Staff Methodist Hospital of Sacramento
Patrice Coyle Retired HR & Education Community Representative	Sister Gabrielle Marie Jones Vice President, Mission Integration Mercy San Juan Medical Center
Sister Patricia Manoli, RSM Director, Mission Integration St. Elizabeth Community Hospital	Linda Ubaldi Director, Risk Management Dignity Health Sacramento Service Area
Roger Neillo Sacramento Chamber of Commerce President; Former California State Assemblyman	Gena Koeberlein Director, Quality Mercy General Hospital
Margaret Thompson Director, Quality Mercy Hospital of Folsom	Wayne Soo Hoo Director, Quality Mercy San Juan Medical Center
Chasity Ware Sr. Director, Quality Methodist	Laurie Harting Sr. Vice President, Operations Dignity Health Sacramento Service Area
Thiru Rajagopal, MD Vice Chief of Staff Mercy General Hospital	Dwight (Brad) Stalker, MD Vice Chief of Staff Mercy Hospital of Folsom
Steven Polansky, MD Vice Chief of Staff Mercy San Juan Medical Center	Timothy Takagi, MD Vice Chief of Staff Methodist
Rae Lynn Stafford Board Coordinator Dignity Health Sacramento Service Area	Rod Winegarner Chief Financial Officer Dignity Health
Martina Evans-Harrison Chief Nurse Executive Methodist Hospital	Joshua Freilich Chief Nurse Executive Mercy Hospital of Folsom

Belva Snyder Chief Nurse Executive Mercy San Juan Medical Center	Mary Carol Todd Chief Nurse Executive Mercy General Hospital
Phyllis Baltz Chief Operating Officer Mercy San Juan Medical Center	Jill Dryer Vice President, Communications Dignity Health Sacramento Service Area
Ian Boase Legal Counsel, Dignity Health	Kelley Evans Legal Counsel, Dignity Health
Gene Bassett President, Methodist Hospital of Sacramento	Edmundo Castaneda President, Mercy General Hospital
Brian Ivie President, Mercy San Juan Medical Center	Michael Ricks President, Mercy Hospital of Folsom
Sister Bridget McCarthy Vice President, Mission Integration Dignity Health Sacramento Service Area	Michael Cox Vice President, Mission Integration Methodist Hospital of Sacramento
Sister Clare Marie Dalton Vice President, Mission Integration Mercy General Hospital	Sister Cornelius O'Conner Vice President, Mission Integration Mercy Hospital of Folsom

Dignity Health Sacramento Service Area Community Board Community Health Committee Roster

Sister Bridget McCarthy
Vice President, Mission Integration
Dignity Health Sacramento Service Area

Jill Dryer
Vice President, Communications
Dignity Health Sacramento Service Area

Sister Clare Marie Dalton
Vice President, Mission Integration
Mercy General Hospital

Patrice Coyle
Retired HR & Education
Community Representative

Sister Cornelius O'Conner
Vice President, Mission Integration
Mercy Hospital of Folsom

Kevin Duggan
President, Mercy Foundation

Sister Gabrielle Marie Jones, Chair
Vice President, Mission Integration
Mercy San Juan Medical Center

Marge Ginsburg
Executive Director
Center for Healthcare Decisions
Community Representative

Michael Cox
Vice President, Mission Integration
Methodist Hospital of Sacramento

Rosemary Younts
Director, Community Benefit
Dignity Health Sacramento Service Area

Ashley Brand
Manager, Community Benefit
Dignity Health Sacramento Service Area

Josh Clapper
Community Benefit Coordinator
Dignity Health Sacramento Service Area

APPENDIX B

Dignity Health Summary of Patient Payment Assistance Policy

DIGNITY HEALTH
SUMMARY OF PATIENT PAYMENT ASSISTANCE POLICY
(June 2012)

Policy Overview:

Dignity Health is committed to providing payment assistance to persons who have health care needs and are uninsured or under-insured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, Dignity Health strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Payment assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Dignity Health's procedures for obtaining payment assistance, and to contribute to the cost of their care based on individual ability to pay. Individuals with financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.

Eligibility for Patient Payment Assistance:

- Eligibility for payment assistance will be considered for those individuals who are uninsured, ineligible for any government health care benefit program, and unable to pay for their care, based upon a determination of financial need in accordance with the policy.
- The granting of payment assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, or immigration status, sexual orientation or religious affiliation.

Determination of Financial Need:

- Financial need will be determined through an individual assessment that may include:
 - a. an application process in which the patient or the patient's guarantor is required to cooperate and supply all documentation necessary to make the determination of financial need;
 - b. the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay;
 - c. a reasonable effort by the Dignity Health facility to explore and assist patients in applying for appropriate alternative sources of payment and coverage from public and private payment programs; and will take into account the patient's assets and other financial resources.
- It is preferred but not required that a request for payment assistance and a determination of financial need occur prior to rendering of services. The need for payment assistance may be re-evaluated at each subsequent rendering of services, or at any time additional information relevant to the eligibility of the patient for payment assistance becomes known.

- Dignity Health’s values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of payment assistance. Requests for payment assistance shall be processed promptly, and the Dignity Health facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

Patient Payment Assistance Guidelines:

Services eligible under the policy will be made available to the patient on a sliding fee scale, in accordance with financial need as determined by the Federal Poverty Level (FPL) in effect at the time of the termination as follows:

- Patients whose income is at or below 200% of the FPL are eligible to receive free care;
- Patients whose income is above 200% but not more than 350% of the FPL are eligible to receive services at the average rates of payment the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater in amount for the same services;
- Patients whose income is above 350% but not more than 500% of the FPL are eligible to receive services at 135% of the average rates the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater for the same services;
- Patients whose income exceeds 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the Dignity Health facility.

Dignity Health’s administrative policy for Eligibility and Application for Payment Assistance shall define what qualifies as income for these purposes.

Communication of the Payment Assistance Program to Patients and the Public:

- Information about patient payment assistance available from Dignity Health, including a contact number, shall be disseminated by the Dignity Health facility by various means, including the publication of notices in patient bills and by posting notices in the Emergency and Admitting Departments, and at other public places as the Dignity Health facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the Dignity Health facility.
- Any member of the Dignity Health facility staff or medical staff may make referral of patients for payment assistance. The patient or a family member, a close friend or associate of the patient may also make a request for payment assistance.

Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient payment assistance will be included within the Social Accountability Budget of the Dignity Health facility. Dignity Health facilities will report patient

payment assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.

- Patient payment assistance statistics shall be disclosed in annual financial statements but shall not include amounts that are properly considered to be bad debt or contractual discounts.

Relationship to Collection Policies:

- Dignity Health system management shall develop policies and procedures for internal and external collection practices by Dignity Health facilities that take into account the extent to which the patient qualifies for payment assistance, a patient's good faith effort to apply for a governmental program or for payment assistance from Dignity Health, and a patient's good faith effort to comply with his or her payment agreements with the Dignity Health facility.
- For patients who qualify for payment assistance and who are cooperating in good faith to resolve their hospital bills, Dignity Health facilities may offer interest-free extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences and will not send unpaid bills to outside collection agencies.

Regulatory Requirements:

In implementing this policy, Dignity Health management and Dignity Health facilities shall comply with all federal, state and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.